3. <u>REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE</u>

If it is determined by a utilization review committee that a Medicaid recipient no longer requires inpatient psychiatric hospital services but must remain in the hospital because a medically necessary long term care bed is not available in the community ("alternate care determination"), and it is determined by the Commissioner that there is a significant excess of operational beds at the hospital or in private psychiatric hospitals located in the OMH region in which the hospital is located, the hospital will be reimbursed at a rate equal to the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate, at the time such services were furnished. For purposes of this paragraph, a significant excess of operational beds exists if the occupancy rate for the hospital for the most recently reported twelve month period is less than 80%, of the hospitals bed capacity, as stated on the operating certificate issued by the Office of Mental Health. A significant excess of operational beds exists in the OMH region if the overall occupancy rate for private psychiatric hospitals in the region is less than 80%. Alternate care days are counted as occupied beds. Effective October 1, 1984, occupancy rates will be determined without including alternate care days.

Alternate care determinations must be reported to the Office of Mental Health ("OMH") on such forms and in such manner as shall be prescribed by OMH. OMH will notify providers of procedures for collecting and reporting data.

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4. Additional Disproportionate Share Payment -

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid-eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made by the Department to disproportionate share hospitals who have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

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A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non- emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

B. RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND YOUTH

Medicaid rates for Residential Treatment Facilities for Children and Youth ("RTFs") are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The RTF fiscal year and rate year are for the twelve months July 1 through June 30. Actual patient days are subject to a maximum utilization of 98 percent and a minimum utilization of 95 percent. For the rate years July 1, 1994 through June 30, 1995 and July 1, 1995 through June 30, 1996 the base year for both rate years for the purpose of setting rates will be July 1, 1992 through June 30, 1993.

1. <u>OPERATING COSTS</u>

Allowable operating costs are subject to the review and approval of the Office of Mental Health. In determining the allowability of costs, the Office of Mental Health reviews the categories of cost, described below, with consideration given to the special needs of the patient population to be served by the RTF. The categories of costs include:

(I) Clinical Care. This category of costs includes salaries and fringe benefits for clinical staff.

(ii) Other than Clinical Care. This category of costs includes the costs associated with administration, maintenance and child support.

Allowable per diem operating costs in the category of clinical care are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount. Clinical services such as dental services, purchased on a contractual basis will be considered allowable and not subjected to the clinical standard if the services are not uniformly provided by all RTFs and thus not considered by the Commissioner in the establishment of the approved staffing levels.

Allowable per diem operating costs in the category of other than clinical care are limited to the lesser of the reported costs or a standard amount.

The standard amounts for the clinical and other than clinical categories are computed as follows. For RTFs located in the New York, City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50% of the average per diem cost for all RTFs in this geographic area and 50% of the average per diem cost for all RTFs in the state; increased by [five] <u>seven and one half</u> percent. For RTFs located outside the New York, City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50% of the average per diem cost for all RTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk Counties and 50% of the average per diem cost for all RTFs in the state; increased by [five] <u>seven and one half</u>.

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New York

Allowable operating costs as determined in the preceding paragraphs will be increased by the Medicare inflation factor for hospitals and units excluded from the prospective payment system. except for the rate period effective July 1, 1995 through June 30, 1996 where no inflation factor will be used to trend costs beyond the July 1, 1994 through June 30, 1995 period.

2. <u>CAPITAL COSTS</u>

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures which are subject to the Office of Mental Health's certificate of need procedures, must be reviewed and approved by the Office of Mental Health.

<u>Transfer of Ownership</u>

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

3. **<u>APPEALS</u>**

The Commissioner may consider requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in service, programs, or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Other rate revisions may be based on additional staffing required to meet accreditation standards of the Joint Commission on Accreditation of Hospitals, or other Federal or State mandated requirements resulting in increased costs. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

4.**<u>RESIDENTIAL TREATMENT FACILITIES WITH INADEQUATE COST EXPERIENCE</u>**

Rates of payment for a residential treatment facility with inadequate cost experience shall be determined on the basis of satisfactory cost projections as submitted to the Commissioner. The rate of payment shall take into consideration total allowable costs, total allowable days and shall be subject to staffing standards as approved by the Commissioner and a limitation on operating expenses as determined by the Commissioner.

Financial reports, reflecting actual cost and statistical information, in a form prescribed by the Commissioner, shall be required within one hundred twenty days following the first six month period during which the Residential Treatment Facility has operated at an average utilization of at least ninety percent or one year after the first resident was admitted to the Residential Treatment Facility, whichever event occurs earlier. The Commissioner may, at his discretion, utilize this cost report to adjust the RTF's budget-based rate of payment to more accurately reflect the costs of operating the facility. In any event, the Commissioner will calculate a cost-based rate for the facility no later than two years after the facility has opened, unless the Commissioner determines that the facility has not achieved the status of a stable, ongoing operation with reliable cost information, in which case the budget based rate will be continued, adjusted as necessary, for updated budget projections as appropriate.

5. **REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE**

Effective twelve months after the date the RTF submits financial reports reflecting actual operating costs or two years after the RTF begins operating, whichever is earlier, if it is determined by a utilization review committee that a Medicaid recipient no longer requires inpatient psychiatric hospital services but must remain in the RTF because a medically necessary long term care bed is not available in the community, and it is determined by the Commissioner that there is a significant excess of operational beds at the RTF or in the RTFs located in the OMH region in which the RTF is located, the RTF will be reimbursed at a rate equal to the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate, at the time such services are furnished. For purposes of this paragraph, a significant excess of operational beds exists if the occupancy rate for the RTF for the most recently reported twelve month period is less than 80% in the case of RTFs with certified bed capacities greater than 20 beds or 60% in the case of RTFs with certified bed capacities of 20 beds or less, as stated on the operating certificate issued by the Office of Mental Health. A significant excess of operational beds exists in an OMH region if the overall occupancy rate for RTFs in the region is less than the weighted average of 80% for RTFs in the region with certified bed capacities greater than 20 beds and 60% for RTFs in the region with certified bed capacities of 20 beds or less. The occupancy rate shall be determined without including alternate care days. The determination of average occupancy rate for RTFs in the region is applied to each of the five geographical OMH regions and is based on RTFs which are subject to the provisions of this section and which are located within the same OMH Region.

Alternate care determinations must be reported to the Office of Mental Health on such forms and in such manner as shall be prescribed by OMH. OMH will notify providers of procedures for collecting and reporting data prior to the effective date of the reduced payment provision.

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6. Additional Disproportionate Share Payment -

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid-eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below.

These additional payment adjustments are made by the Department to disproportionate share hospitals who have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program. These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

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A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non- emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

New York State Office of Alcoholism and Substance Abuse Services (OASAS)

SUMMARY OF INPATIENT MEDICAID PAYMENT METHODOLOGY FOR SERVICES IN PRIVATE PSYCHIATRIC HOSPITALS

OASAS establishes all inclusive program specific per diem rates on a prospective basis. Rates are established on the basis of certified cost reports which are submitted at least one year prior to the first day of the rate year which is the calendar year. For example, rates for the 1994 calendar year rate year were based upon 1992 calendar year data. A rolling base year is utilized, i.e. each year, rates are re-calculated using a new base year.

Allowable operating and capital costs from the base year are determined in accordance with Medicare Principles of Reimbursement (HIM-15) and Generally Accepted Accounting Principles (GAAP). Increases in operating costs from base year to base year are limited by application of a growth factor. The growth factor changes each year and is defined as the trend factor for the base year plus 2%.

A trend factor is then added to the lower of a program's base year operating costs or the operating costs as limited by the growth factor. The trend factor is developed for OASAS by the NYS Office of Health Systems Management (OHSM). The trend factor has two components, personal services and non-personal services. Calculation of the personal services component is multi-step process. First, personal services costs are broken down into various categories, i.e., managerial and administrative, professional and technical, clerical, service occupations and blue collar. Each category is then assigned a sub-weight representing its percentage relationship to total personal services costs. The assigned subweight is then multiplied by the price movement for each of these categories using United States Department of Labor, Bureau of Labor statistics. The sum percentage of these calculations is then multiplied by a percentage representing personal services costs to total costs. The non personal services component is determined by multiplying the GNP implicit price deflator by a percentage representing non personal costs to total costs. The trend factor for the 1994 rate year is 2.99%.

The program specific per diem rate is then calculated by dividing the sum of allowable trended adjusted operating costs and allowable capital costs by the higher of actual patient days (in the base year) or 90% of possible base year days for inpatient rehabilitation programs; for primary care (detoxification) programs, the higher of actual base year patient days or 85% of possible base year days is used. Possible days for each program is calculated by multiplying the certified bed capacity by the number of days in the base year, i.e. either 365 or 366. Rates which are based upon actual certified costs data are provisional pending audit. There is a process for a provider to appeal a provisional rate.

For new providers with inadequate cost experience, rates are calculated on the basis of a program specific 12 month budgeted cost report. As with actual cost based rates, allowable operating and capital costs are determined in accordance with HIM-15 and GAAP. Unlike actual cost based programs, operating costs will be limited to 115% of the statewide average for similar programs. The sum of allowable adjusted operating costs and allowable capital costs is then divided by the higher of budgeted days or 90%/85% of possible days to arrive at a budgeted per diem. Budgeted based rates are adjusted to actual rates upon receipt of actual certified cost reports. Program specific provisional rates are then established retroactively to the effective date of the budgeted rate.

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